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Committee

Larry E. Craig, Chairman
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No. 88

Legislative Notice

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S. 2330 — Patients' Bill of Rights Act

Calendar No. 479

Bill was read the second time on July 20, 1998, and placed on the Calendar. No committee report.

NOTEWORTHY

- S. 2330 is the product of the GOP Healthcare Task Force, chaired by Senator Nickles and composed of Senators Jeffords, Frist, Gramm, Hagel, Collins, Roth, Coats, and Santorum. Appointed in January, the task force met extensively — collecting information from outside experts, reviewing specific proposals and drafting a bill.
- At press time, the Majority Leader's attempts to reach unanimous consent to govern the consideration of S. 2330 (the first formal offer was extended on June 18) had not been realized. With last night's rejection of another unanimous consent offer by Minority Leader Daschle, the Minority has now rejected four formal UC requests on this legislation.
- On July 24, the House passed its healthcare reform bill, H.R. 4250, by a vote of 216-210, after defeating, by a vote of 212-217, a competing Democratic bill. The White House issued a veto threat on H.R. 4250.

HIGHLIGHTS

The Republican Patients' Bill of Rights:

- **Safeguards the rights of 48 million Americans** enrolled in health insurance plans currently exempt from state regulation without intruding on historical areas of state regulation;
- **Provides the right of independent, expedited, externalized, and binding appeal** to 124 million Americans if they believe their plan wrongly denied them covered benefits;

- **Increases access** by opening the insurance doors to some 42 million Americans who are uninsured for at least part of a given year. Access is increased by:

  — Making insurance to those self-employed immediately (as of next January) 100-percent deductible. Of the 25 million Americans in families headed by a **self-employed individual,** some 5 million are uninsured.

  — Enhancing FSAs by allowing for a $500-end-of-year carryover. More than half of full-time employees in large and medium-size firms are eligible for **Flexible Spending Arrangements (FSAs).**

  — Enhancing the innovative **Medical Savings Accounts (MSA)** option, and making that option available to *all* Americans.

S. 2330 is a comprehensive reform proposal that *not only* addresses Americans' concerns that their rights be assured in healthcare coverage, *but also assures* that their access to care, and the quality of that care, will improve. S. 2330 is a patients' rights bill, plus it provides :

- Increased access to private health insurance;
- Increased quality: one section of the bill focuses on women's health issues, and another creates an agency dedicated exclusively to improving health care quality;
- Increased confidentiality of patient information: safeguards patients' privacy on the use of genetic information and prohibits the intrusive use of such information.

BACKGROUND

As of July 29, the Majority Leader had extended four formal unanimous consent requests to the minority. Taken together, these have met the minority's evolving demands. All of these have been rejected. [See RPC paper, "Democrats Won't Take 'Yes' for an Answer," 7/30/98, for details and chronology of the offers.]

The Minority Leader has made one attempt to force a vote on the Democrats' legislation by attaching a modified version of their legislation, S.1890, to the VA-HUD appropriations bill on July 7 but withdrew the amendment on July 16.

None of the health reform proposals — neither the two considered by the House (one Republican and one Democratic) nor the two Senate bills discussed in this Notice — has been

reported by a committee. However, the Senate task force's members include the two chairmen of the relevant committees, Labor and Finance.

House Action

On July 24, 1998, and under threat of a recommended veto, the House passed its healthcare reform bill, H.R. 4250 by a vote of 216-210. The care bill offers a method to appeal denials of coverage; a ban on gag rules; an expansion of medical savings accounts; and purchasing pools to allow small businesses and associations to buy health insurance more cheaply than is now possible. CBO estimates that the House GOP bill would reduce the average medical insurance premium by 0.1 percent, while the Democratic alternative (defeated, 212-217) would raise premiums by about 4 percent.

BILL PROVISIONS

Title I: Patients' Bill of Rights

The Republican bill provides that there will no longer be any health plans that are beyond the scope of either federal or state safeguards. It specifically amends the federal law governing self-insured employers (both large and small) providing healthcare benefits, known as the Employee Retirement Income Security Act (ERISA), so that plans which are currently exempt from state regulation will have to meet the following federal standards:

- **Access to Emergency Care:** The so-called "prudent layperson" standard is adopted so that emergency medical screening is guaranteed in those instances when an individual prudently deems himself to be in a medical crisis situation. The bill furthermore extends the guarantee so that any medical services deemed necessary by a trained medical technician is also guaranteed. Billing for such care must be treated as if the care were preauthorized.

- **Point-of-Service Coverage (POS):** Health plans that currently only provide care through a system of limited health care providers (such as an HMO) must offer participants the option to receive care outside this system. This can be done by either offering two or more plans that differ significantly in the providers used or the networks of such providers. Firms of 50 or fewer employees are exempt from this provision and higher premiums and cost-sharing may be attached to the POS option.

- **Guaranteed Ob-Gyn Access:** Group plans must allow women to receive routine covered obstetrical and gynecological care without first receiving approval from a "gatekeeper."

- **Guaranteed Pediatric Coverage:** Group plans must allow access to pediatricians for covered services without a primary care doctor's prior authorization.

- **Continuity of Care:** Insurers that terminate their contract with a provider must: a) notify participants of the termination; and b) continue the care through that provider for a period of up to 90 days when the enrollee is receiving institutional or inpatient care, or in the case of pregnancy for a participant who has entered the second trimester, the care is continued through the provision of post-partum care (or later) of a pregnancy, or for a patient who is terminally ill, the care is continued for the remainder of the individual's life.

- **Banning Gag Rules:** So-called "gag rules" are banned in accordance with the prohibition passed in last year's Balanced Budget Act and the President's directive that banned these in the federal Medicare and Medicaid programs. This prohibition includes "conscience clause" language that will exempt those organizations with religious and moral objections (such as Catholic hospitals being required to counsel on abortion) from this requirement.

- **Required Patient Information:** ERISA plans would have to provide their participants with information regarding: covered items, and services and such in- and out-of-network features as are applicable; beneficiary cost-sharing requirements; the plan's optional supplemental benefits; payment restrictions in the case of services from nonparticipating providers; the plan's services area and its provisions relating to out-of-area coverage; enrollees' options for selecting their primary health care provider; advance directives and organ donation procedures; preauthorization requirements and procedures; rules and methods for grievance and appeals filings; access to emergency care; determination whether coverage applies to experimental and investigational treatments or clinical trials; and preventive services.

- **Requested Patient Information:** Patients may request, and plans must provide, information on: the plan's contract with the network health professional, the professional's state licensure, and (if available) the qualifications of the professional; the participating healthcare facilities; reimbursement methods between the plan and its participating health professionals and facilities; utilization review procedures; prescription medicines included in the plan's formulary and procedures (if any) for obtaining off-formulary medications; specific exclusions under the plan's coverage; availability of translation or interpretation services for non-English speakers and the disabled; and publicly available plan accrediting organizations.

- **Information on Providers:** The bill authorizes the Institute of Medicine to study and provide recommendations for disclosure of provider competency and qualifications.

- **Patient Recourse Options:** Plans and issuers must establish utilization review procedures that: 1) allow beneficiaries to determine their eligibility for specific health service coverage; 2) notify covered enrollees and their treating professionals of determinations; 3) require plans to respond to written and oral enrollee and health professional requests for coverage determination; and 4) require plans and issuers to make

routine authorizations within 30 working days, and within 72 hours if the treating professional determines that delay could jeopardize an enrollee's health.

- **Grievance and Appeals Procedures:** All employee benefit plans must have a written procedure for handling beneficiary grievances relating to: waiting periods, operating hours, personnel behavior, and facility adequacy (but not regarding coverage determinations) — these determinations cannot be appealed. Plans must have both an internal and an external appeals procedure.

  — **Internal Appeals Procedure:** Beneficiaries and health professionals can appeal adverse prior authorization determinations. Plans must address these within 30 days in routine cases, and in an expedited fashion when medical conditions require. All reviews must be conducted by an unbiased expert who was not involved in the original decision.

  — **External Appeals Procedure:** The external review provisions will ensure both an expedited and truly outside decision-making process for the beneficiary. Its results are binding on the health plan. Beneficiaries and health professionals can appeal to independent medical experts adverse internal review determinations that are: 1) consistent with the terms and conditions of the plan contract; and 2) exceed a $1,000 threshold and are based on medical necessity or appropriateness; or 3) involve an experimental or investigational treatment determination where the health of the beneficiary is in danger. Reviewers must: 1) be credentialed and licensed within the state; 2) have no affiliation with the case, beneficiary, health professional, facility, drug manufacturer, etc.; 3) be experts in treatment of the condition in question; and 4) not be held liable for their decisions. Such decisions are to be evidence-based and timely.

Title II: Patient Medical Records

- A beneficiary or his designee has the right to inspect and copy the beneficiary's medical records, except in cases where such information could endanger that person's physical safety or in related cases.

- In most cases, beneficiaries are allowed to amend their protected health records. All plan-associated health professionals and facilities are required to post their confidentiality practices and to establish appropriate safeguards for such patient information.

- The bill imposes civil penalties in the event of violations of these patient rights.

Title III: Genetic Information

- **Genetic Testing and Information:** For all Americans, the use of predictive genetic information is prohibited for the denial of coverage or to set premium rates.

Title IV: Health Care Quality Research

The Republican bill ensures that quality will remain high, and will be increased through private-sector innovation in the following ways:

- **Establishes the Agency for Healthcare Quality Research (AHQR):** This refocuses the existing agency's mission to encourage the overall improvement of private-sector healthcare through advanced information technology, public private partnerships, and the dissemination of the latest scientific-based quality information. This is *not* a new bureaucracy, but the re-focusing of an existing one — the Agency for Health Care Policy and Research. AHQR's role is *not* to mandate but to facilitate, through the dissemination of uniform standards, annual reports on the state of quality and cost of America's health care, support of state-of-the-art information systems, support of primary care research in underserved rural and urban areas, technology assessment, and coordination of the federal government's own quality improvement efforts. A modified form of S. 2208 is included.

Title V: Women's Health Research and Prevention

The area of women's health care historically has been under-studied. With an aging population — in which women make up an increasing majority — women's health care concerns require special attention. S. 2330 specifically focuses on the particular problems in women's healthcare by:

- Including the mastectomy provisions authored by Senator D'Amato that allow for a 48-hour hospital stay for patients without the need for prior authorization. If a plan covers mastectomies, it must also include reconstructive procedures.

- Extending through 2001 expiring authorities for osteoporosis and related bone disorder research, breast and ovarian cancers, and women's geriatric studies.

- Establishing a national program for public and health professional education on the drug diethylstilbestrol (DES).

- Requiring NIH to fund research expanding the study of the causes and prevention of cardiovascular disease in women — the leading cause of death in women in this country.

- Extending through 2002, the authorization of the Family Violence Prevention and Services Act.

- Supporting data collection through the National Center for Health Statistics and the National Program of Cancer Registries — the leading women's health data centers.

Title VI: Increased Access to Health Insurance Coverage

Access is the foremost concern Americans have about their health care system — they are concerned both about their ability to afford healthcare, and their ability to stay in a good plan once they can afford it. More than 15 percent of all Americans (about 41.6 million people) are uninsured for at least part of a given year. This is America's most serious private health insurance problem. In contrast to the Kennedy bill (which will result in decreased access, due in part to increased litigation provisions, including making employers liable, that alone will force as many as 1.8 million Americans out of coverage in 1999, and will force millions more to pay much more in higher premiums), the Republican bill increases access by:

- **Self-employed deductibility:** This bill immediately gives equal tax treatment to the self-employed's health insurance expenses. The Joint Committee on Taxation (JCT) estimates that 3 million self-employed individuals will benefit from increasing the deductibility of health insurance to 100 percent (for the self-employed who are not currently eligible to participate in an employer-provided plan), effective January 1, 1999. More than 25 million people live in families headed by a self-employed individual (5.1 million of whom are currently uninsured). Currently, the self-employed can deduct only 45 percent of their health insurance expenses (under current law, full deductibility will not be provided until 2007).

  Cost: JCT estimates that this provision will cost $3.1 billion over five years and $7.3 billion over ten years.

- **Enhancing Flexible Spending Arrangements (FSA):** CRS reports that 52 percent of full-time employees in large and medium-size firms were eligible for FSAs in 1993. This bill gives those individuals the ability to carry forward up to $500 in their accounts from one year to the next. FSA funds are provided through a so-called "cafeteria plan" whereby an employee may use nontaxable dollars to pay for certain allowable employer-provided benefits. While such money is not counted as an employee's income for tax purposes, current law provides that money remaining in the FSA at year's end is forfeited. The Republican bill would allow up to $500 to be carried forward to the next year in an FSA account.

  Cost: JCT estimates that this provision will cost $1.1 billion over five years and $1.7 billion over ten years.

- **MSAs:** This bill gives all individuals the right to MSAs (medical savings accounts) and puts MSAs on an equal tax treatment footing with standard health care insurance. Participants in the Federal Employees Health Benefits Program (FEHB, which covers 4.9

million individuals), the nearly 42 million uninsured, and everyone else will all be eligible for MSAs. These innovative and flexible savings plans are currently only available for employees in firms of 50 or fewer employees and in a very restricted form. (Under current law, the maximum employer contribution can only be 65 percent of the deductible of the required high-deductible plan of at least $1,500, no more than $2,250 for individual coverage, and 75 percent of between a $3,000 and $4,500 deductible for a family. The total number of such plans is capped at 750,000, and after December 31, 2000, no new MSAs may be opened. Current law also provides that any withdrawals for nonmedical purposes be included as income and be subject to a 15-percent penalty.)

- The current-law restrictions on MSAs have served to minimize the use of this option — but the Republican bill makes this a real and highly desirable alternative (or supplement) to standard health insurance.

- The Republican bill removes the cap on the total allowable number of MSAs (they would become unlimited), eliminates the small-employer restriction, ends the program's sunset, allows FEHBP participants to use this option, and relaxes the contribution restrictions as follows: 1) the minimum high-deductible amount would be lowered to $1,000 for individuals (and $2,000 for a family); and 2) the contribution could equal 100 percent of this deductible. It allows any insurance company licensed in a state and any individual to purchase a high-deductible policy that meets the definitions in the tax code.

- Furthermore, any amounts above that necessary to cover the current year's deductible would be eligible for withdrawal without the current 15-percent tax penalty.

- **Cost:** The total cost of the tax provisions has been officially estimated by JCT to cost approximately $6.5 billion over 5 years and $12.1 billion over 10 years.

ADMINISTRATION POSITION

At press time, no official Statement of Administration Policy had been released, but the Office of Management and Budget did release on July 23, 1998, a "Statement of Administration Policy" on the House bill that stated that "the Administration strongly opposes H.R. 4250. . . . The President's senior advisors would recommend that he veto this bill."

COST

No CBO cost estimate is yet available. However, the JCT revenue estimate of the tax provisions is $6.5 billion over five years and $12.086 billion over ten years and the indirect revenue effect (from lost revenues to the Treasury due to the indirect effects of the legislation) is $1.2 billion over five years and $1.456 billion over ten years. Together the total revenue effect will be $7.7 billion over five years and $13.5 billion over ten years. Finance Committee Chairman Roth, a member of the task force, has stated that the bill's costs will be fully offset in a "noncontroversial" manner and will be included in a manager's amendment.

— The $13.5 billion figure matches the $13.5 billion figure that the Kennedy bill has identified for its offset; and is just one-third of the amount identified for a tax cut in the Senate-passed FY 1999 budget resolution.

In contrast, the modified version of S. 1890 that was offered as an amendment to the VA-HUD appropriations bill earlier this month has used several offsets that are very controversial — including an extension of Superfund taxes.

Another aspect of cost is that which will result from premium increases. According to CBO, S. 1890 would almost double CBO's expected increase of 5.5 percent to 9.5 percent. According to CBO's July 16 estimate, S. 1890 would cost the federal government $10.4 billion in reduced revenues and increased spending over 10 years; it would also cost the private sector $24.9 billion over five years. In contrast, the House bill, which S. 2330 more closely resembles, was estimated by CBO to slightly reduce premiums by 0.1 percent.

POSSIBLE AMENDMENTS

The Minority has not agreed to terms for a floor debate and it is therefore unclear what the amendment process, if any, would be. However, the Majority Leader has always assured the Minority a vote on their version of health care legislation.

Daschle/Kennedy. Substitute their bill, S. 1890, in a modified form to provide offsets. [Note, the Daschle/Kennedy bill would expand the right to sue both insurers and employers and extend federal regulation to all health plans — even those already state-regulated. For details, see the following RPC papers: "The Kennedy-Daschle Bill: Healthcare Reform in Reverse," 7/8/98; "Clinton-Care and Kennedy-Care: Deja Vu All Over Again," 7/15/98; Republican Plan Gives Patients a Bill of Rights; Democrats Give Lawyers the Right to Bill," 7/20/98; and "Patients' Rights: Republicans Target the Problem; Democrats Target the Politics," 7/21/98.

Manager's Amendment. Containing provisions to offset the cost under the PAYGO provisions of the Budget Act and technical corrections.

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